shorn. Think of the effect upon the incomes of some of our contemporaries of propaganda advocating the administration of antibiotics after each extramarital intercourse! If each patient is then to be observed and tested for 2 to 3 years then is the future safe for the venereologist, but the bankruptcy court and madhouse loom for the anxious patient.

I submit that abortive treatment for the venereal diseases is unsound, perhaps ineffective, and often harmful. I believe that we should strive to discourage a method which is a departure from fundamental principles and has been advocated without mature consideration and without proper evidence as to its efficacy.

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DISCUSSION

THE PRESIDENT said that statements for and against had been put very clearly, and it was for each individual now to make up his own mind as to which method was the best. He was a little worried about all this indiscriminate treatment. Medicine ceased to be medicine if one went about the world sticking a needle into everyone who could be caught. He had seen a patient recently who was syphilophobic; she had been given a course of antisyphilitic treatment which made her considerably worse and now she did not know whether she had been infected and cured or what had happened to her. What the ultimate result would be he did not know.

The problem of prophylactics worried him considerably at times. He worked in a clinic at Covent Garden and had a large number of prophylactic patients, people who came to London, indulged, and then came for prophylactic treatment. They seemed to think they could dominate and dictate to the physician; in fact, some who had been to various centres near the American camps would come and ask for a shot of penicillin. This was frequently refused; his own reaction was that they should take the prophylaxis given by the clinic or go elsewhere; he was not having them come in and tell him what treatment they would have. He found that the average persistent prophylactic individual was very irresponsible and one who certainly would not come for any degree of follow-up. With many it was very difficult and sometimes impossible to get them to have a blood test, in spite of frequent casual exposures.

The other point he would like to find out was: what was the legal position if a physician treated a patient for a disease that he might not in fact have? Was one really doing the best for the patient? Personally, he did not think so because some were being put into a state of considerable doubt that might easily result in phobia.

DR. C. S. NICOL said that he was definitely against abortive treatment. It seemed to him that this should not be considered as a global problem, because, after all, most of the members were practising medicine in Great Britain. Dr. Willcox, in discussing the method of mass treatment, had mentioned many disorders which were not venereal diseases. Dr. Willcox had particularly mentioned the survey on endemic syphilis in Jugoslavia where abortive treatment was sometimes given to a whole village. Could one imagine what would happen in an English village if one turned up with a van and equipment, knocked at the front-doors, and told people one had come to give them all injections? Some would certainly ask why, and the reply would be, "To make sure you do not get syphilis"! He would rather not think of what Dr. Willcox meant by a "sweep of the population" in Poland; such methods could not be used in Great Britain.

In relation to the problem of treating the consorts of patients with early syphilis, he would agree that one had to make exceptions, particularly for women in the late stages of pregnancy. It did not follow that because one made an exception, the principle had to be accepted.

He was particularly interested in the question of treating women who were the contacts of men with gonorrhoea. Dr. Willcox had said he would take two sets of genital tests and serological tests before giving abortive treatment. He agreed that there was a high incidence of gonorrhoea in these female contacts; it was his experience at the Whitechapel Clinic of the London Hospital that the figure would be 80 per cent. After the necessary 3 months' surveillance of the 20 per cent. who did not give positive smears or cultures one assumed that they were not infected. He did not think it was any

excuse to say that some clinics had a poor culture service. If they had, they should take steps to improve it. He would have said that with a good culture service the great majority of female contacts who had gonorrhoea would give positive smear and culture results after two sets of tests. He did not feel, therefore, that there was anything to be gained by prophylaxis in this instance.

Dr. Willcox had mentioned a 3 months' follow-up for female contacts of males with gonorrhoea who were given a routine injection of penicillin; this period of follow-up should presumably be 6 months. Dr. Willcox had compared the prophylactic use of the Early Treatment packet with antibiotic prophylaxis, but whereas there was no danger that calomel ointment would produce resistant organisms, these could certainly be produced by antibiotics *in vitro*. He suggested that the statement by the Central Council for Health Education in their propaganda campaign and quoted by Dr. Willcox should be altered. The difficulty about prophylactic treatment with other antibiotics was that some of these drugs could be taken by mouth. One had seen what happened to the cure rate of gonorrhoea in the Central Mediterranean Forces in the recent war. He had always understood that the high treatment failure with the sulphonamides had been caused through a few of these tablets being handed round to most of the prostitutes in the brothels. He would have thought that there might have been a similar danger in Korea if oral antibiotics had been handed out by medical orderlies to the United Nations Forces, so that in due course these tablets got into the hands of the female contacts.

Mr. King had dealt with the problem of relieving the patient's anxiety as far as possible and he was wholly in agreement with his ideas on this subject. The only true prophylaxis against venereal infection was the reduction of promiscuity. The British Federation Against Venereal Diseases hoped to promote various schemes with this objective in view. This was the way the problem should be tackled, rather than by abortive treatment.

Dr. Mascall had mentioned the problem of the patient who came in and asked for a prophylactic injection. It was never the practice in the clinics in which he worked to give such prophylaxis. The greatest danger of accepting a policy of giving abortive treatment to certain categories of patients was that this would need expert judgment on the part of the clinicians. Could they be certain that such expert judgment would always be available when such patients presented themselves?

DR. G. L. M. MCELLIGOTT congratulated both of the opening speakers, each of whom approached the problem from an entirely different angle. He personally would hate to see the almost veterinary methods of the mass campaign used in the treatment and control of the venereal diseases in Great Britain. He thought there was little or nothing to be said in favour of the penicillin prophylaxis of gonorrhoea, and a good deal to be said against it. It was now an easily cured disease, and cases should be treated as they arose, every effort being made to trace and treat the contacts. The practice of pressing prophylactics on young National Service men was particularly pernicious.

Chronic gonorrhoea in women is often difficult to diagnose; default after one negative examination is all too common, and there is much to be said in favour of treating all female contacts of known male cases, even when smears and cultures show no gonococci. It should, of course, be explained to these patients that treatment was being given on an insurance basis as far as gonorrhoea was concerned, though he had found that the clinical response of many cases of apparently non-gonococcal cervicitis to penicillin was often excellent. None of them refrained from treating non-gonococcal urethritis empirically, and in their present state of ignorance it seemed justifiable to treat its female counterpart the same.

The "clinic" incidence of gonorrhoea had been rising since early in 1952, and the possibility that a strain-resistance to penicillin might be beginning must be borne in mind. Many would remember how thousands of cases of sulphonamide-resistant gonorrhoea encumbered the Service hospitals in Italy in 1943, but few knew that the infecting gonococci in these cases were found to be sulphonamide-sensitive *in vitro*.

He agreed completely with the President that insurance treatment of the venereophobe was bad practice. The phobia, often due to a guilt complex, was usually not cured, and "the last state was worse than the first". Contacts of known syphilitics should normally never be treated before diagnosis, the sole exception being the pregnant woman exposed to a likely risk of infection.

DR. EVA GALLAGHER said that her feelings in the matter had been summed up by Mr. King when he said that it was better to know where one was going before setting out. She thought Dr. McElligott was hard on himself and his colleagues on the question of clinical diagnosis. If the male patient had gonorrhoea and the doctor had good reason to believe that relapse followed contact with his wife, that was a reasonable ground for making a diagnosis of gonorrhoea in the wife. Giving prophylaxis to a man on the way home after incurring a risk was a totally different matter. All one knew was that the man had had intercourse with a woman who might have had syphilis, or chancroid, or for that matter diphtheria. It would be very interesting to know what effect penicillin had had on conditions other than venereal in those populations which had been so freely subjected to injections. It was not impossible that penicillin-resistant organisms of other diseases would be bred by the indiscriminate use of the antibiotic.

DR. R. C. L. BATCHELOR wondered if venereologists could advocate treatment before diagnosis in the venereal diseases found in Great Britain without incurring a risk of loss of prestige. All venereologists had ample facilities for making diagnoses, and physicians and general practitioners expected these facilities to be used. If it became known that specialists were advocating and practising treatment before diagnosis, where would this lead? Most of those present had seen the ingenious "pressure ampoules", and knew that some promis-

cuously inclined individuals carried these about, saying that they did not need to go to a specialist because all he would do would be to give them a " shot " of penicillin which they could quite well administer to themselves.

If treatment were given before diagnosis in potential cases, i.e. in actual infections of gonorrhoea or syphilis during the incubation period, the implications of these infections would be delayed and would become very different from what they would have been had a firm diagnosis been made. For instance, a patient who had been exposed to a non-gonococcal urethritis might be accepted as a potential case of gonorrhoea and might be given penicillin. If he had really been infected with gonorrhoea then his wife might have been involved through contact during the incubation period. On the other hand, if from the nature of his exposure he had merely developed a simple non-specific urethritis, it could be cleared up quickly and without carrying a serious threat to his wife.

Delayed diagnosis might delay the following-up of consorts. If a firm diagnosis of gonorrhoea were made and it proved possible to trace the consort, she could be followed-up, but could she be followed-up in a case of non-specific urethritis? He himself had been asked to do this, but questioned whether it was advisable.

With regard to diagnostic tests, these were not excluded by Dr. Willcox, who advocated that they should be made so that they could help to explain the case after treatment had been given. If this were done, was it not better that the tests should be continued until the diagnosis was made apparent and the actual disease to be treated was made known?

He thought that if specialists were to advocate this idea of treatment before and without diagnosis, the prestige of venereologists would suffer.

DR. ROBERT LEES remarked that it was premature to judge the effect of the WHO treatment schemes for the treponematoses, and that these schemes had little in common with the subject under discussion, which was the treatment of venereal disease before (or without) diagnosis. He could not recall any instance in which a specific chemotherapeutic agent had produced an appreciable fall in the incidence of any disease. Prophylactic immunization was a quite different proposition but it was not available for the venereal diseases.

In his opinion, the prevention of venereal disease would follow application of the epidemiological principles which were well known and widely accepted.

Any lowering of the standards of diagnosis, or excuses for dispensing with the best standards available in the circumstances, was to be strongly resisted.

COL. L. W. HARRISON said there was little left for him to say, except that he was in general agreement with the obvious feeling of the meeting against the indiscriminate use of antibiotics. He was particularly interested in the use of these and other agents for the prophylactic treatment of syphilis. He thought it a most short-sighted policy and likely to produce an army of syphilophobes. He thought that the practice of such measures in the Services was likely to promote resistance to antibiotics; it was not beyond belief that the unwise use of these antibiotics would largely put them out of action as had already happened with the sulphonamides so far as gonorrhoea was concerned.

DR. A. O. F. ROSS posed the question of children born to infected mothers. Obviously such children had been in contact with a possible source of infection. Would anyone consider it proper to treat them because of that?

On the subject of effective prophylactic treatment for syphilis he quoted the case of a girl exposed to infection on one sole occasion; 4 weeks later she developed a primary lesion of the vulva in which *Treponema pallidum* was demonstrated. This was in August, 1953. Her consort, an American serviceman, was found to have been treated in May for acute gonorrhoea by 900,000 units of PAM. In September he had no signs of syphilis and his S.T.S. was negative, yet from this history it would appear that he was an infectious case of syphilis.

DR. ELIZABETH KEIGHLEY said she was in full agreement with diagnosis before treatment, but there was a class of people who should be treated a little differently, and that was the prostitute class with whom she came into contact. They used measures such as douching which prolonged the incubation period. She had tested them two or three times a week for a month, and it had taken her a full month or 6 weeks to find the gonococcus, although one might suspect it clinically. In 2 weeks all one could find were a few extracellular organisms. It made one think there should be some other rules which would involve an alteration of the law of prostitution to make these people come for regular tests or to be inside some hospital where they could be observed, instead of being subjected to regular fines, which equally amounted to organized prostitution. All of them douched well and heartily with Dettol or some other disinfectant and it took a month or six weeks to wear off. This made one think oneself justified in treating such cases on a clinical diagnosis before the gonococcus was demonstrated.

DR. E. M. C. DUNLOP felt that on certain occasions the patient, when given all the facts, must decide. He recalled a doctor working on the Treponemal Immobilization Test who jabbed his hand with a needle containing treponemes. After deliberation this doctor elected to have " prophylactic " treatment and to be followed-up for 2 years. Some of the difficulties in the way of diagnosis could be overcome. He himself worked in part at a seaport, and one of the most efficient ship's doctors he knew treated his patients with urethral discharges himself. This doctor took a smear before treatment, fixed it, and gave it to the patient, who brought it to the shore clinic with a record of the treatment given at sea. This was a way in which diagnosis could be arrived at despite difficulties. Now that treatment was so very easy, skilled diagnosis was the best way in which venereologists could help both their patients and their colleagues.